

# Mental Health and Addiction Services Development Board Loan Repayment Assistance Application Packet

## **Eligible Applicants:**

Psychiatrists

Psychologists

Psychiatric nurses

Addiction counselors

Mental health professionals (licensed or license track)

Current Indiana Residents or Prospective Indiana Residents



***Indiana Division of Mental Health and Addiction***

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**Indiana Mental Health and Addiction Services Development Board**  
**Loan Repayment Assistance Program**  
**For Mental Health and Addiction Professionals**  
**OVERVIEW AND TERMS OF AGREEMENT**

The Indiana FSSA, Division of Mental Health and Addiction (DMHA), is the designated state agency to administer the Mental Health and Addiction Services Loan Repayment Assistance Program for the State of Indiana. This program provides repayment assistance of eligible educational loans for full-time psychiatrists, psychologists, addiction counselors and mental health professionals, who are licensed or on a licensure track. The intent of the program is to expand the workforce within the specified practice areas by encouraging the recruitment and retention of mental health and addiction professionals who will establish practices or accept positions within the State of Indiana.

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<b>TERMS OF SERVICE AGREEMENT</b>
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NAME: \_\_\_\_\_

In consideration of the student loan repayment assistance for which I have been offered, under HB 1360, I hereby agree to the following:

**Employment:**

1. I will remain employed full time (30 hours per week minimum) in my specified mental health and/or addiction position for a period of service not less than twelve (12) months. I will notify DMHA, by email and within 48 hours, of any transfer to a new position or of my intention to voluntarily separate, resign, or retire from my position. In the event that I voluntarily leave my position or if I am involuntarily separated before completing the agreed upon period of service, I will be indebted to the Mental Health and Addiction Services Loan Repayment Assistance Program and must reimburse DMHA for the full amount of any student loan repayments made on my behalf under this service agreement. I further acknowledge that a sum equal to the amount that I am required to repay is recoverable by law.
2. Periods of leave without pay, or other periods during which I am not in pay status, does not count toward the required service period, and the service completion date must be extended by the total time spent in non-pay status. Absence due to uniformed service in a recognized branch of the United States military authorized maternity/paternity leave, FMLA or due to compensable injury, however, is considered creditable within the sole discretion of the Mental Health and Addictions Development Programs Board.

**Eligibility:**

3. I must be in good standing for repayment for any federal student loans.
4. I must be licensed to practice psychiatry, psychology, addictions or mental health counseling or be on track to obtain licensure.
5. I must be either a new college graduate accepting a position or a new Indiana resident establishing a practice in Indiana in the field areas listed above.

**Loan Management:**

6. The Mental Health and Addiction Services Loan Repayment Assistance Selection Committee and DMHA as the disbursement agency is not responsible for the management of my loans or for fees assessed to my educational loans and will not negotiate with lenders how payments are to be applied. Loan Repayment Assistance made on my behalf does not exempt me from responsibility and/or liability for the full amount of any loan in which I am the debtor.
7. The State of Indiana will pay my lender a one-time payment directly based on the information I provided. As individual lenders may have different processes as to how the payments get applied it is my responsibility to discuss this with my lender.
8. I authorize DMHA to verify the status, payment history, and outstanding balance of each qualifying loan, and to discuss the terms with the lender or note holder when applicable.
9. I will be required to submit to DMHA an employment verification form every six (6) months. If it is determined that I am out of compliance with program requirements, the Mental Health and Addiction Service Development Programs Board will review the information to determine a course of action.

**Tax Information:**

10. I understand that if awarded loan forgiveness benefits that I will be required to complete, sign and return a Vendor Information Form as the State Auditor will need this information to prepare a 1099 reporting form for this taxable income.
11. Any loan repayments made on my behalf may be taxable and subject to withholding. I am responsible for any income tax obligation resulting from the student loan repayment made on my behalf.

**Awardees' Responsibilities and Expectations:**

12. I must provide DMHA with any changes to my contact information (e.g. name change, mailing address, email, or telephone number) prior to the change occurring, if possible, or immediately after the change occurs.
13. The award of loan repayment assistance in any fiscal year does not guarantee future benefits i.e., and awards are subject to the availability of appropriations.
14. Repayment benefits made on my behalf cannot exceed \$25,000 in any calendar year for more than four (4) years with the exception for addiction psychiatry which is no more than five (5) years. This limitation should not, under any circumstances, be construed as an obligation of said benefits.

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**SIGNATURE**

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**DATE**

**Indiana Mental Health and Addiction Services Development Board**  
**APPLICATION PACKET**  
**Loan Repayment Assistance Program**  
**For Mental Health and Addiction Professionals**  
**Authorized by HEA 1360**

Please type (in bold) or print your answers.

**Section A: Certification**

I understand that an application packet will not be considered complete unless the following documents are submitted:

1. **Application:** Complete and sign the form.
2. **Proof of Employment:** Complete the top portion of the *Employment Verification* form and have your employer complete the lower portion of the form or employment plan.
3. **Proof of Loans:** Submit a National Student Loan Data Systems (NSLDS) ([www.NSLDS.ed.gov](http://www.NSLDS.ed.gov)) statement as well as a Loan Verification Release Form for *each lender/servicer* who administers or holds any of your student loans. The NSLDS statement must contain all of the required loan information as outlined on the Loan Verification Release Form.
4. **Proof of financial information:** You must submit a copy of the most recent Federal Form 1040 you have filed. Your financial information will be kept confidential.
5. **Service Agreement:** Complete and sign the Loan Repayment Program Service Agreement.
6. **Personal Statement:** Submit a personal statement highlighting public service and a commitment to continued public service.
7. **Letter of Recommendation:** Submit a letter of recommendation from your current employer, to include their belief of your commitment to stay employed there for a minimum of one year.
8. **Transcripts:** Submit school transcripts.
9. **Resume:** Submit a copy of your current resume including your employment and education history as well as any notable professional affiliations or achievements.

I understand that the full application packet must be received by April 30, 2015.

All the information on this application is true and complete to the best of my knowledge. If asked by the Mental Health and Addiction Services Development Board, I will provide proof of the information I have given on this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

## Section B: Applicant Information

Name (Last, First, MI): \_\_\_\_\_

Employer: \_\_\_\_\_

Position/Discipline: ☐ Addiction Psychiatrist  
☐ Addiction Counselor  
☐ Psychiatrist  
☐ Psychologist  
☐ Psychiatric Nurse  
☐ Mental Health Counselor

Date of Hire: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Email Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Are you employed full-time? (*A minimum of 30 hours/week*) ☐ Yes ☐ No

Home Phone: \_\_\_\_\_

Personal Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

### **Licensure**

In which state(s) are you licensed?

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
License number (s) # \_\_\_\_\_

\_\_\_\_\_

In what state are you currently practicing?

\_\_\_\_\_

If not licensed, please explain your current efforts to obtain licensure. (*Please use an additional sheet if needed.*)

\_\_\_\_\_

Degree and Institution:

\_\_\_\_\_

Year Obtained: \_\_\_\_\_

## Section C: Educational Debt

Please list all eligible loans and totals at the bottom of the page. The following loans are eligible for repayment:

1. A loan made, insured, or guaranteed under part B of subchapter IV of chapter 28 of Title 20 (Federal Family Education Loan Program);
2. A loan made under part C or D of subchapter IV of chapter 28 of Title 20 (William D. Ford Federal Direct Loan and Federal Perkins Loans);
3. A loan made under section 1078-3 or 1087e (g) of Title 20 (Federal consolidation loans and Federal Direct Consolidation loans, respectively).
4. \*Other educational loans may be considered and is subject to approval by the Mental Health and Addictions Services Development Programs Board.

The first listed loan will be the one that your benefits are paid to. If funds awarded are sufficient to completely pay the balance due on that loan, the excess of the award will be paid to the second loan listed. You are required to disclose whether any of the loans listed below are financed through other educational loan repayment or forgiveness programs and/or grants.

Lender/Service	Outstanding Balance	Monthly Payment	Months Remaining	Other Source(s) of Loan Assistance

Total Original Loan Amount:

\_\_\_\_\_

Total Outstanding Balance:

\_\_\_\_\_

Total Monthly Payment:

\_\_\_\_\_

Total Amount Paid Against Loan To Date:

\_\_\_\_\_

Total Adjusted Gross Income:

\_\_\_\_\_ (as stated on most recent 1040 filed)

# Mental Health and Addiction Services Development Program Employment Verification Form

## Section D: Employment Verification *(completed by applicant)*

Name (Last, First, MI): \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

I authorize my employer to provide the employment information requested by the Indiana MENTAL HEALTH AND ADDICTION SERVICES DEVELOPMENT PROGRAM.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\*\*\*\*\*

*( This section completed by employer)*

The above named employee has applied for benefits from the Indiana MENTAL HEALTH AND ADDICTION SERVICES DEVELOPMENT PROGRAM. Please complete the following section and return this form to the applicant.

Job Title of Employee: \_\_\_\_\_

Date of Hire \_\_\_\_\_

Applicant employed full-time: ☐ Yes ☐ No (a minimum of 30 hours/week)

Name of Organization: \_\_\_\_\_

Organization Address: \_\_\_\_\_

Office location (city) of employee: \_\_\_\_\_

Current Annual Salary: \_\_\_\_\_

### Underserved/Shortage Areas:

☐ Applicant employment location is in an underserved county/region with limited access to mental health and addiction professionals and/or related services according to the recent data provided by the Health Resources and Services Administration (<http://muafind.hrsa.gov/index.aspx>).

I verify that the information provided above is true and complete to the best of my knowledge and that the applicant meets the requirements established by the Indiana MENTAL HEALTH AND ADDICTION SERVICES DEVELOPMENT PROGRAM.

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Telephone Number

## Mental Health and Addiction Services Development Program Loan Verification Release Form

### Section E: Release of Information

The applicant must submit a NSLDS statement for each eligible educational loan that contains the information listed below. If the statement does not contain all the required information, the applicant should write in the rest of the information. *Incomplete statements will not be accepted.*

#### Required Loan Information

- Name of Lender
- Address of Lender
- Account Number
- Type of Loan (Federal Direct, etc.)
- Outstanding Balance
- Type of Repayment Plan
- Loan Status (current, deferral, etc.)

\*\*\*\*\*

Complete the release below to give permission to the **Indiana Mental Health and Addiction Services Development Program** to obtain additional information, if needed. Make copies of the form if needed for multiple lenders.

#### Release (to be completed by applicant)

Account Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Name (Last, First, MI):: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

I authorize my lender \_\_\_\_\_; to provide the loan information requested by the **Indiana MENTAL HEALTH AND ADDICTION SERVICES DEVELOPMENT PROGRAM.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



## **Mental Health and Addiction Services Development Program**

**Section F: Personal Statement** *(A brief statement of 250 words or less highlighting mental health and/or addiction experience and ongoing commitment to this field.)*